

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN
DISTRICT OF TENNESSEE, AT GREENEVILLE:

BARBARA WELCH

Plaintiff

CASE NO.: _____

VERSUS

JURY DEMANDED

BALLAD HEALTH

Defendant

COMPLAINT

1. This case arises under **28 USC § 1332**. The amount in controversy exceeds **Seventy-Five Thousand (\$75,000.00) Dollars**.

2. Plaintiff is a citizen and resident of Washington County, Virginia. Defendant is a Tennessee corporation with situs and principal place of business situate in Washington County, Tennessee, and which may be served by serving its registered agent for service of process, Timothy Belisle, 400 North State of Franklin Rd., and/or 303 Med Tech Parkway, Johnson City, Tennessee, 37604.

3. Plaintiff avers that all acts of health care liability to be set forth herein occurred in Sullivan County, Tennessee, at Ballard Health-Bristol Regional Medical Center, owned and/or operated by defendant, and situate in Bristol, Tennessee.

4 On **February 19, 2020**, pursuant to the mandates of **TCA §29-26-121(a)**, written notice was given to the defendant of the potential claims of the plaintiff sounding in healthcare liability. Plaintiff, further, avers that the notice contained all the

requirements set forth by **TCA §29-26-121(a)(2)**, and further, that notice was timely received by the defendant, more than sixty (60) days prior to the filing of this litigation, in accordance with **TCA §29-26-121(a) (4)**.

5. Plaintiff avers that the instant litigation (a) is filed within one year of the date a reasonable person knew or could have known of the deviation from the accepted medical standard of care, as extended by the 120-day pre-suit notice extension; (b) that the litigation has been commenced after sixty (60) days from the date of the mailing of the pre-suit notice, and prior to the expiration of the one (1) year statute of limitations for health care liability actions, again, said statute of limitation being extended by the 120-day pre-suit notice extension, and, (c) that the litigation has been commenced within the three-year statute of repose.

6. Attached hereto and incorporated herewith as **collective Exhibit A**, as required pursuant to **TCA §29-26-121(b)**, are (a) a copy of all pre-suit notice letters sent to the defendant, fully compliant with the terms and provisions of the Healthcare Liability Act; (b) copies of all the postage receipts for same; (c) copies of all of the medical authorizations sent with each pre-suit notice letter, which plaintiff avers are fully **HIPAA-compliant**, and (d) copies of the certified mail receipts for each recipient sent such pre-suit notice on behalf of the defendant.

7. Pursuant to the mandates of **TCA §29-26-122**, attached hereto and incorporated herewith as **Exhibit B** to this Complaint is a Certificate of Good Faith as required by the aforesaid statute. Plaintiff, further, avers that this Certificate of Good Faith is fully compliant with the aforesaid statute.

8. Attached hereto and incorporated herewith as **Exhibit C** is the affidavit of plaintiff's counsel and his secretary, both of whom caused to be prepared, prepared and sent all items required to comply with the pre-suit notice provisions of Tennessee's Health Care Liability Act, stating that plaintiff complied with the pre-suit notice requisites of the Health Care Liability Act. Affirmatively, plaintiff avers that all requirements of the pre-suit notice provisions of the Healthcare Liability Act for the instant proceeding have been fully complied with.

Plaintiff having averred that she has complied with all necessary requisites to the filing of this Complaint, she, further, avers as follows:

9. On or about March 3rd or 4th, 2019, plaintiff avers that she entered Bristol Regional Medical Center, which was then and there owned and/or operated by defendant, in order that an operation could be performed upon her.

10. Subsequent to the operation, plaintiff was transferred to Bristol Regional's ICU, due to the fact that she had a blockage in, among other places, her right lower extremity. A stent was placed in the blockage to open it up.

11. In order to assist the opening of the blockage, and in order to increase the blood flow to the affected leg, the nursing staff, and others under control of the nursing staff at Bristol Regional Medical Center—and, thus, all agents, servants, and employees of defendant, Ballad Health—applied nitroglycerin ointment, a/k/a “nitro paste,” to plaintiff's right foot.

Plaintiff, upon information and belief, states that, to this point, the nursing staff had acted within the standard of care for ICU nurses and other nurses in Bristol, Tennessee/Virginia for treatment of such maladies as plaintiff presented. However,

plaintiff avers that the subsequent acts which followed were absolutely deviations from the standard of nursing care in Bristol Tennessee/Virginia and similar locales for the treatments of persons suffering such maladies as plaintiff.

12. Plaintiff avers that the defendant's agents, servants, and employees applied the nitro paste not once, but several times to the same place. Plaintiff, further, avers that the nitro paste was wrapped in a **heated bandage not once, not twice, but three times.**

As the direct and proximate result of the negligent acts aforesaid, plaintiff's right foot was seared as if she had been branded like cattle. A typical four or five day hospital stay from the time she presented at Bristol Regional Medical Center to the time she would have been discharged turned into a three (3) month stay at three (3) different facilities. Plaintiff suffered excruciatingly. As a direct and proximate result, plaintiff's leg had to be amputated at approximately the right knee.

13. Plaintiff incorporates Paragraphs 1 through 12, above, of the premises to this Complaint. She avers that the defendant and its agents, servants, and employees knew what the standard of care was for increasing blood flow to the lower extremities of a post-operative patient in Bristol, Tennessee/Virginia in March, 2019. Plaintiff, further, avers that defendant, its agents, servants, and employees (particularly its nursing staff) deviated from said standard of care, and that, as a direct and proximate result thereof, plaintiff sustained damages.

14. Plaintiff incorporates Paragraphs 1 through 13 above, of the premises to this Complaint. She avers that defendant, its agents, servants, and employees, knew what the standard of care was for providing informed consent—if, indeed, slathering on

nitro paste and wrapping it in a heated wrap three times is within the standard of care for nursing staff in the Bristol Tennessee/Virginia area when attempting to increase blood flow to a post-operative patient's lower extremities, which plaintiff highly doubts—as to what adverse causes and effects putting more nitro paste on a lower extremity and wrapping it with a heated wrap three times would occur in patients such as plaintiff, whose blood flow needed to be increased post-operatively to the lower extremity. Plaintiff, further, avers that defendant, its agents, servants and employees, deviated from said standard of care, in that—if, again, this defendant uses the poor excuse “well, she knew what we were doing—plaintiff was not adequately informed to make an adequate decision about her medical care.

Plaintiff, further, avers that, as the direct and proximate result of the defendant's, its agents', servants', and employees', violation of the standard of care regarding informed consent, she sustained damages.

15. Plaintiff incorporates Paragraphs 1 through 14, above, of the premises to this Complaint. She avers that, as a direct and proximate result of the deviations from the medical standard of care described above, she has sustained great physical and mental pain, suffering, and emotional distress, and that she will sustain same in the future.

Plaintiff, further, avers that, to date, she has expended and/or onerated herself to expend the sum of \$_____ in health care bills, which have not been paid by a third-party, and will sustain same in the future. Plaintiff, further, avers that, to date, she has come under the care of numerous medical professionals, has been hospitalized several times, both at defendant's and at other facilities, has been hospitalized in an acute care mental facility, due to the enormous mental burden upon her of losing her right leg

as a result of this medical “screw up,” and that she shall require such care in the future. She avers that her injuries are painful and permanent in nature.

Plaintiff, prior to this incident, had been able to take care of her husband, who is presently suffering from the effects of dementia and Alzheimer’s. Her care of her husband since March, 2019, has been drastically curtailed, as the direct and proximate result of this medical negligence.

16. Plaintiff incorporates Paragraphs 1 through 15 of the premises to this Complaint and avers that this is a proper case for punitive damages. First, the defendant, its agents, servants and employees, grossly deviated from the accepted standard of ICU nursing care in Bristol Tennessee/Virginia and similar communities. Plaintiff avers that one does not slather on nitro paste onto an individual as if it were peanut butter on bread, much less slap it copiously on the affected area and then wrap it three times with a heated wrap. A layperson can say—although Ballard will never admit—that this is grossly deviant from the standard of care. Nitro paste, a heating agent, in combination with, in essence, a “hot towel” from a barber shop, is certainly going to brand a human like a cow.

Secondly, it appears as if defendant and its staff have attempted to cover up the record, although they did a poor job in covering it up. For example, many notations in plaintiff’s chart regarding the use of nitro paste have been amended. What was also amended was the gratuitous insertion of a chart entry that plaintiff is allergic to nitro paste, perhaps to show that the nitro paste was not lathered onto her.

Plaintiff is not, and never has been, allergic to nitro paste. Thus, this is a deliberate attempt by defendant and its agents to falsify plaintiff’s records, and is also proof that the defendant knew it had committed malpractice, but is attempting to hide it.

WHEREFORE, plaintiff demands judgment against defendant in the sum of **One Million, Five Hundred Thousand (\$1,500,000.00) Dollars** in compensatory damages, including any unpaid medical bills pursuant to **T.C.A. § 29-26-119**, and demands judgment for punitive damages to the maximum extent allowed by statute **[T.C.A. § 29-39-104 (a)(5)]**.

Plaintiff demands a jury to try this case.

BARBARA WELCH

By: 

Francis X. Santore, Jr.
Of Counsel, BPR #011315

SANTORE AND SANTORE
Attorneys at Law
P. O. Box 113
Greeneville, TN 37744-0113
423-639-3511

Attorneys for Plaintiffs

PLAINTIFF'S EXHIBIT A:

- 1. Copies of pre-suit notice letters sent to defendant and/or its authorized agent(s)**
- 2. Copies of receipt for certified postage paid**
- 3. Copies of receipts executed by addressees for certified mail ("green cards")**
- 4. Copies of HIPAA-compliant medical authorizations sent with certified mail above**

SANTORE & SANTORE
ATTORNEYS AT LAW
121 E. DEPOT ST.
GREENEVILLE, TENNESSEE 37744

SERVING THE PUBLIC AND THE PROFESSION SINCE 1965

FRANCIS X. SANTORE (1931 - 2004)

FRANCIS X. SANTORE, JR. *

P.O. Box 113
(423) 639-3511
Fax (423) 639-0394

February 19, 2020

Mr. Alan Levine
President, CEO and COO
BALLAD HEALTH
400 North State of Franklin Rd.
Johnson City, TN 37604

Mr. Alan Levine
President, CEO and COO
BALLAD HEALTH
303 Med Tech Parkway
Johnson City, TN 37604

Mr. Timothy Belisle, Esq.
General Counsel
BALLAD HEALTH
400 North State of Franklin Rd.
Johnson City, TN 37604

Mr. Timothy Belisle, Esq.
General Counsel
BALLAD HEALTH
303 Med Tech Parkway
Johnson City, TN 37604

SENT TO EACH ADDRESSEE VIA CERTIFIED MAIL

Dear Mr. Levine and Mr. Belisle:

Pursuant to the auspices of TCA § 29-26-121, this firm is hereby submitting to you the required pre-suit notice under the Tennessee Healthcare Liability Act. Pursuant to the aforesaid statute, please note the following information.

1. Pursuant to TCA § 29-26-121 (a) (2) (A) the full name and date of birth of the patient whose treatment is at issue is **Barbara Welch, date of birth February 20, 1945.**
2. Pursuant to TCA § 29-26-121 (a) (2) (B), the name and address of the claimant authorizing this notice is **Barbara Welch, 19374 Benhams Road, Bristol, VA 24202.**

Mr. Alan Levine
Mr. Timothy Belisle
February 19, 2020
Page 2

3. Pursuant to TCA § 29-26-121 (a) (2) (C), the name and address of the attorney sending the notice is **Francis X. Santore, Jr., SANTORE AND SANTORE, Attorneys at Law, 121 East Depot St., P. O. Box 113, Greeneville, TN 37744-0113.**

4. Pursuant to TCA § 29-26-121 (a) (2) (D), the following is a list of the names and addresses of all providers being sent a notice:

**BALLAD HEALTH
c/o Mr. Alan Levine,
President, CEO, and COO and
c/o Mr. Timothy Belisle, Esq.,
General Counsel
400 North State of Franklin Rd.
(and 303 Med Tech Parkway)
Johnson City, TN 37604**

5. Pursuant to the terms and provisions of TCA § 29-26-121 (a) (2) (E), you will find enclosed herewith certain Medical Authorizations, fully compliant under HIPAA, which will permit each provider listed in ¶ 4 above to obtain the complete medical records from each other provider being sent a notice.


Yours truly,



~~SANTORE AND SANTORE~~

Francis X. Santore, Jr.

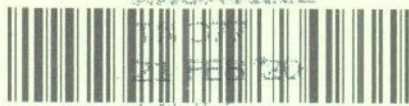
Enclosures

cc: Ms. Barbara Welch

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<p>■ Complete items 1, 2, and 3.</p> <p>■ Print your name and address on the reverse so that we can return the card to you.</p> <p>■ Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p style="font-family: cursive; font-size: 1.2em;">Mr Alan Levine President, CEO and COO BALLAD HEALTH 303 Med Tech Pkwy Johnson City, TN 37604</p> <div style="text-align: center;">  9590 9402 4937 9063 7192 57 </div> <p>2. Article Number (Transfer from service label)</p> <div style="border: 1px solid black; padding: 2px; text-align: center; font-family: monospace; font-size: 1.1em;">7009 2250 0000 9621 3565</div>	<p>A. Signature</p> <p>X <i>Adrian Miller</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery </p>
PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt	

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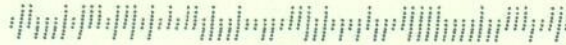


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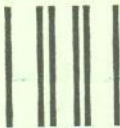
Mr. Francis X. Santore Jr.
Santore & Santore
PO Box 113
Greeneville, TN 37744-0113



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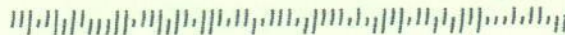



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SANTORE & SANTORE
PO Box 113
Greeneville, TN 37744-0113



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<p>2. Article Number (Transfer from service label) <div style="border: 1px solid black; padding: 2px; display: inline-block;">7009 2250 0000 9621 3572</div></p>	<p>3. Service Type <i>WELCH</i> <input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Registered Mail™</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery</p>

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<p>2. Article Number (Transfer from service label) <div style="border: 1px solid black; padding: 2px; display: inline-block;">7009 2250 0000 9621 3596</div></p>	<p>3. Service Type <i>WELCH</i> <input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Registered Mail™</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery</p>

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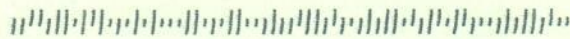


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General Counsel
Ballad Health
303 Main Tech Pkwy
Johnson City, TN 37604
PS Form 3800, August 2006 See Reverse for Instructions

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Pres. CEO & COO
Ballad Health
303 Main Tech Pkwy
Johnson City, TN 37604
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Total Postage & Fees	\$

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President, CEO
Ballad Health
400 N. State & Franklin Rd
Johnson City, TN 37604
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Total Postage & Fees	\$

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Sent To *Mr. Timothy Belisle, Esq*
Gen. Counsel
Ballad Health
400 N. State & Franklin Rd
Johnson City, TN 37604
PS Form 3800, August 2006 See Reverse for Instructions

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: BALLAD HEALTH-BRISTOL REG. MED. CENTER
ATTENTION: Medical Records
1 Medical Park Blvd.
Bristol, TN 37620

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

In connection therewith, I hereby authorize any doctors, nurses, x-ray technicians, chiropractors, osteopathic physicians, psychiatrists, psychologists, therapists, specialists, any and all other medical personnel and healthcare facilities or providers of any kind and nature to disclose to and provide copies of the above information to the following: **BALLAD HEALTH, ATTN: Mr. Alan Levine and/or Mr. Timothy Belisle, 400 North State of Franklin Rd. (and/or 303 Med Tech Parkway) Johnson City, TN 37604**

b. General Provisions

The scope of the dates of the records to be provided is as follows: **January 1, 2019 to date and beyond (this is a continuing authorization)**

The authorization is valid until **January 1, 2022**.

The purpose of this authorization, release and access is as follows: **to settle and/or defend a potential action against Ballad Health, pursuant to, and as required by, the Tennessee Healthcare Liability Act.**

By my signature below, I understand and agree (a) that once the above information is disclosed, there is potential for the designated recipient, unless prohibited by Federal or State statute or court/administrative order, to redisclose the information requested, and that the information may no longer be protected by Federal or State privacy laws and/or regulations; (b) that the provider furnishing the copies may receive compensation for doing so; (c) that I may refuse to give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons

give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons or entities authorized to receive this information as designated above, except that a revocation of this Authorization will not apply to records already received before its revocation; (e) that (1) I am at least eighteen (18) years of age, and of sound mind as of the date of my execution of this Authorization, and that no force, threats, coercion or other intimidation has been utilized to procure my signature below, OR (2) that, if I am the parent, conservator, legal guardian, and/or custodian of a person either not of legal age, or adjudged legally incompetent, if of legal age, I am legally authorized to execute this Authorization on this person's behalf, and I do so without the application of force, threats, coercion or other intimidation.

9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

~~COMMONWEALTH OF VIRGINIA~~ STATE OF TENNESSEE

~~COUNTY OF WASHINGTON~~ SULLIVAN

Personally appeared before me, a Notary Public in and for the State and County aforesaid, the within named bargainer, **BARBARA LEIGH JANE WELCH**, with whom I am personally acquainted, or whose identity has been sufficiently proven to me, and who acknowledged that he/she executed the within named document, consisting of **two (2)** typewritten pages, for the purposes therein contained.

Witness my hand at office this 6 day of SEPTEMBER 20 19.

[Signature]
Notary Public

My commission expires: 7/24/23



My Commission Expires July 17, 2021

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: Dr. Joseph T. Chun
ATTENTION: Medical Records
1934 Alcoa Highway, Suite 362
Knoxville, TN 37920

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

In connection therewith, I hereby authorize any doctors, nurses, x-ray technicians, chiropractors, osteopathic physicians, psychiatrists, psychologists, therapists, specialists, any and all other medical personnel and healthcare facilities or providers of any kind and nature to disclose to and provide copies of the above information to the following: **BALLAD HEALTH, ATTN: Mr. Alan Levine and/or Mr. Timothy Belisle, 400 North State of Franklin Rd. (and/or 303 Med Tech Parkway) Johnson City, TN 37604**

b. General Provisions

The scope of the dates of the records to be provided is as follows: **January 1, 2019 to date and beyond (this is a continuing authorization)**

The authorization is valid until **January 1, 2022**.

The purpose of this authorization, release and access is as follows: **to settle and/or defend a potential action against Ballard Health, pursuant to, and as required by, the Tennessee Healthcare Liability Act.**

By my signature below, I understand and agree (a) that once the above information is disclosed, there is potential for the designated recipient, unless prohibited by Federal or State statute or court/administrative order, to redisclose the information requested, and that the information may no longer be protected by Federal or State privacy laws and/or regulations; (b) that the provider furnishing the copies may receive compensation for doing so; (c) that I may refuse to give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons

give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons or entities authorized to receive this information as designated above, except that a revocation of this Authorization will not apply to records already received before its revocation; (e) that (1) I am at least eighteen (18) years of age, and of sound mind as of the date of my execution of this Authorization, and that no force, threats, coercion or other intimidation has been utilized to procure my signature below, OR (2) that, if I am the parent, conservator, legal guardian, and/or custodian of a person either not of legal age, or adjudged legally incompetent, if of legal age, I am legally authorized to execute this Authorization on this person's behalf, and I do so without the application of force, threats, coercion or other intimidation.

9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

~~COMMONWEALTH OF VIRGINIA~~ STATE OF TENNESSEE
SULLIVAN
COUNTY OF WASHINGTON

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[Signature]
Notary Public

My commission expires: 7/24/23



My Commission Expires July 17, 2021

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: ABINGDON HEALTH AND REHAB CENTER
ATTENTION: Medical Records
15051 Harmony Hills Lane
Abingdon, VA 24211

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

In connection therewith, I hereby authorize any doctors, nurses, x-ray technicians, chiropractors, osteopathic physicians, psychiatrists, psychologists, therapists, specialists, any and all other medical personnel and healthcare facilities or providers of any kind and nature to disclose to and provide copies of the above information to the following: **BALLAD HEALTH, ATTN: Mr. Alan Levine and/or Mr. Timothy Belisle, 400 North State of Franklin Rd. (and/or 303 Med Tech Parkway) Johnson City, TN 37604**

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9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

~~COMMONWEALTH OF VIRGINIA~~ STATE OF TENNESSEE

~~COUNTY OF WASHINGTON~~ SULLIVAN

Personally appeared before me, a Notary Public in and for the State and County aforesaid, the within named bargainer, **BARBARA LEIGH JANE WELCH**, with whom I am personally acquainted, or whose identity has been sufficiently proven to me, and who acknowledged that he/she executed the within named document, consisting of **two (2)** typewritten pages, for the purposes therein contained.

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[Signature]
Notary Public

My commission expires: 7/24/23



My Commission Expires July 17, 2021

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: ABINGDON AMBULANCE SERVICE
ATTENTION: Medical Records
611 Campus Drive, Suite 600
Abingdon, VA 24210

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

In connection therewith, I hereby authorize any doctors, nurses, x-ray technicians, chiropractors, osteopathic physicians, psychiatrists, psychologists, therapists, specialists, any and all other medical personnel and healthcare facilities or providers of any kind and nature to disclose to and provide copies of the above information to the following: **BALLAD HEALTH, ATTN: Mr. Alan Levine and/or Mr. Timothy Belisle, 400 North State of Franklin Rd. (and/or 303 Med Tech Parkway) Johnson City, TN 37604**

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9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

~~COMMONWEALTH OF VIRGINIA~~ STATE OF TENNESSEE

COUNTY OF WASHINGTON Sullivan

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My commission expires: 7/24/23



My Commission Expires July 17, 2021

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: BRISTOL SURGICAL ASSOCIATES
ATTENTION: Medical Records
1 Medical Park Blvd., 250 West
Bristol, TN 37620

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

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9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: **N/A**)

~~COMMONWEALTH OF VIRGINIA~~ STATE OF TENNESSEE
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[Signature]
Notary Public

My commission expires: 7/24/23



My Commission Expires July 17, 2021

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: ADVANCED HOME CARE
ATTENTION: Medical Records
P. O. Box 580089
Charlotte, NC 28258-0089

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

**a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and
state laws, regulations and case/administrative decisions:**

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

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9/6/2019
Date

Barbara Leigh Jane Welch
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Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

~~COMMONWEALTH OF VIRGINIA~~ STATE OF TENNESSEE
COUNTY OF WASHINGTON SULLIVAN

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**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: Dr. Brett Odum
ATTENTION: Medical Records
240 Medical Park Blvd.
Bristol, TN 37620

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

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9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

COMMONWEALTH OF VIRGINIA STATE OF TENNESSEE

COUNTY OF WASHINGTON SULLIVAN

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**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: Dr. Joseph Foley
ATTENTION: Medical Records
271 Medical Park Blvd.
Bristol, TN 37620

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

In connection therewith, I hereby authorize any doctors, nurses, x-ray technicians, chiropractors, osteopathic physicians, psychiatrists, psychologists, therapists, specialists, any and all other medical personnel and healthcare facilities or providers of any kind and nature to disclose to and provide copies of the above information to the following: **BALLAD HEALTH, ATTN: Mr. Alan Levine and/or Mr. Timothy Belisle, 400 North State of Franklin Rd. (and/or 303 Med Tech Parkway) Johnson City, TN 37604**

b. General Provisions

The scope of the dates of the records to be provided is as follows: **January 1, 2019 to date and beyond (this is a continuing authorization)**

The authorization is valid until **January 1, 2022**.

The purpose of this authorization, release and access is as follows: **to settle and/or defend a potential action against Ballard Health, pursuant to, and as required by, the Tennessee Healthcare Liability Act.**

By my signature below, I understand and agree (a) that once the above information is disclosed, there is potential for the designated recipient, unless prohibited by Federal or State statute or court/administrative order, to redisclose the information requested, and that the information may no longer be protected by Federal or State privacy laws and/or regulations; (b) that the provider furnishing the copies may receive compensation for doing so; (c) that I may refuse to give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons

give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons or entities authorized to receive this information as designated above, except that a revocation of this Authorization will not apply to records already received before its revocation; (e) that (1) I am at least eighteen (18) years of age, and of sound mind as of the date of my execution of this Authorization, and that no force, threats, coercion or other intimidation has been utilized to procure my signature below, OR (2) that, if I am the parent, conservator, legal guardian, and/or custodian of a person either not of legal age, or adjudged legally incompetent, if of legal age, I am legally authorized to execute this Authorization on this person's behalf, and I do so without the application of force, threats, coercion or other intimidation.

9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative


(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

~~COMMONWEALTH OF VIRGINIA~~ STATE OF TENNESSEE

COUNTY OF WASHINGTON SULLIVAN

Personally appeared before me, a Notary Public in and for the State and County aforesaid, the within named bargainer, **BARBARA LEIGH JANE WELCH**, with whom I am personally acquainted, or whose identity has been sufficiently proven to me, and who acknowledged that he/she executed the within named document, consisting of **two (2)** typewritten pages, for the purposes therein contained.

Witness my hand at office this 6 day of SEPTEMBER, 20 19.


Notary Public

My commission expires: 7/24/23



My Commission Expires July 17, 2021

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: Dr. Pierre Istfan
ATTENTION: Medical Records
1 Medical Park Blvd.
Bristol, TN 37620

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

In connection therewith, I hereby authorize any doctors, nurses, x-ray technicians, chiropractors, osteopathic physicians, psychiatrists, psychologists, therapists, specialists, any and all other medical personnel and healthcare facilities or providers of any kind and nature to disclose to and provide copies of the above information to the following: **BALLAD HEALTH, ATTN: Mr. Alan Levine and/or Mr. Timothy Belisle, 400 North State of Franklin Rd. (and/or 303 Med Tech Parkway) Johnson City, TN 37604**

b. General Provisions

The scope of the dates of the records to be provided is as follows: **January 1, 2019 to date and beyond (this is a continuing authorization)**

The authorization is valid until **January 1, 2022**.

The purpose of this authorization, release and access is as follows: **to settle and/or defend a potential action against Ballard Health, pursuant to, and as required by, the Tennessee Healthcare Liability Act.**

By my signature below, I understand and agree (a) that once the above information is disclosed, there is potential for the designated recipient, unless prohibited by Federal or State statute or court/administrative order, to redisclose the information requested, and that the information may no longer be protected by Federal or State privacy laws and/or regulations; (b) that the provider furnishing the copies may receive compensation for doing so; (c) that I may refuse to give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons

give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons or entities authorized to receive this information as designated above, except that a revocation of this Authorization will not apply to records already received before its revocation; (e) that (1) I am at least eighteen (18) years of age, and of sound mind as of the date of my execution of this Authorization, and that no force, threats, coercion or other intimidation has been utilized to procure my signature below, OR (2) that, if I am the parent, conservator, legal guardian, and/or custodian of a person either not of legal age, or adjudged legally incompetent, if of legal age, I am legally authorized to execute this Authorization on this person's behalf, and I do so without the application of force, threats, coercion or other intimidation.

9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

COMMONWEALTH OF VIRGINIA STATE OF TENNESSEE

COUNTY OF WASHINGTON SULLIVAN

Personally appeared before me, a Notary Public in and for the State and County aforesaid, the within named bargainer, **BARBARA LEIGH JANE WELCH**, with whom I am personally acquainted, or whose identity has been sufficiently proven to me, and who acknowledged that he/she executed the within named document, consisting of **two (2)** typewritten pages, for the purposes therein contained.

Witness my hand at office this 6 day of SEPTEMBER 20 19.


Notary Public

My commission expires: 7/24/23.



My Commission Expires July 17, 2021

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: Dr. Manoj Srinath
ATTENTION: Medical Records
235 Medical Park Blvd.
Bristol, TN 37620

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

In connection therewith, I hereby authorize any doctors, nurses, x-ray technicians, chiropractors, osteopathic physicians, psychiatrists, psychologists, therapists, specialists, any and all other medical personnel and healthcare facilities or providers of any kind and nature to disclose to and provide copies of the above information to the following: **BALLAD HEALTH, ATTN: Mr. Alan Levine and/or Mr. Timothy Belisle, 400 North State of Franklin Rd. (and/or 303 Med Tech Parkway) Johnson City, TN 37604**

b. General Provisions

The scope of the dates of the records to be provided is as follows: **January 1, 2019 to date and beyond (this is a continuing authorization)**

The authorization is valid until **January 1, 2022**.

The purpose of this authorization, release and access is as follows: **to settle and/or defend a potential action against Ballard Health, pursuant to, and as required by, the Tennessee Healthcare Liability Act.**

By my signature below, I understand and agree (a) that once the above information is disclosed, there is potential for the designated recipient, unless prohibited by Federal or State statute or court/administrative order, to redisclose the information requested, and that the information may no longer be protected by Federal or State privacy laws and/or regulations; (b) that the provider furnishing the copies may receive compensation for doing so; (c) that I may refuse to give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons

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9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

COMMONWEALTH OF VIRGINIA STATE OF TENNESSEE

COUNTY OF WASHINGTON SULLIVAN

Personally appeared before me, a Notary Public in and for the State and County aforesaid, the within named bargainer, **BARBARA LEIGH JANE WELCH**, with whom I am personally acquainted, or whose identity has been sufficiently proven to me, and who acknowledged that he/she executed the within named document, consisting of **two (2)** typewritten pages, for the purposes therein contained.

Witness my hand at office this 6 day of SEPTEMBER 20 19.

[Signature]
Notary Public

My commission expires: 7/24/23



My Commission Expires July 17, 2021

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: WOODRIDGE HOSPITAL
ATTENTION: Medical Records
403 N. State of Franklin Rd.
Johnson City, TN 37604

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

In connection therewith, I hereby authorize any doctors, nurses, x-ray technicians, chiropractors, osteopathic physicians, psychiatrists, psychologists, therapists, specialists, any and all other medical personnel and healthcare facilities or providers of any kind and nature to disclose to and provide copies of the above information to the following: **BALLAD HEALTH, ATTN: Mr. Alan Levine and/or Mr. Timothy Belisle, 400 North State of Franklin Rd. (and/or 303 Med Tech Parkway) Johnson City, TN 37604**

b. General Provisions

The scope of the dates of the records to be provided is as follows: **January 1, 2019 to date and beyond (this is a continuing authorization)**

The authorization is valid until **January 1, 2022**.

The purpose of this authorization, release and access is as follows: **to settle and/or defend a potential action against Ballard Health, pursuant to, and as required by, the Tennessee Healthcare Liability Act.**

By my signature below, I understand and agree (a) that once the above information is disclosed, there is potential for the designated recipient, unless prohibited by Federal or State statute or court/administrative order, to redisclose the information requested, and that the information may no longer be protected by Federal or State privacy laws and/or regulations; (b) that the provider furnishing the copies may receive compensation for doing so; (c) that I may refuse to give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons

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9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

COMMONWEALTH OF VIRGINIA STATE OF TENNESSEE

COUNTY OF WASHINGTON Sullivan

Personally appeared before me, a Notary Public in and for the State and County aforesaid, the within named bargainer, **BARBARA LEIGH JANE WELCH**, with whom I am personally acquainted, or whose identity has been sufficiently proven to me, and who acknowledged that he/she executed the within named document, consisting of **two (2)** typewritten pages, for the purposes therein contained.

Witness my hand at office this 6 day of SEPTEMBER, 20 19.

Notary Public

My commission expires: 7/24/23



My Commission Expires July 17, 2021

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and
EDUCATION RECORDS INFORMATION**

TO: BRISTOL REGIONAL COUNSELING (FRONTIER HEALTH)
ATTENTION: Medical Records
26 Midway Street
Bristol, TN 37620

RE: Barbara Welch
SS#: 228-60-0602
DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, **Barbara Welch**, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

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b. General Provisions

The scope of the dates of the records to be provided is as follows: **January 1, 2019 to date and beyond (this is a continuing authorization)**

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By my signature below, I understand and agree (a) that once the above information is disclosed, there is potential for the designated recipient, unless prohibited by Federal or State statute or court/administrative order, to redisclose the information requested, and that the information may no longer be protected by Federal or State privacy laws and/or regulations; (b) that the provider furnishing the copies may receive compensation for doing so; (c) that I may refuse to give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons

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9/6/2019
Date

Barbara Leigh Jane Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative


(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

~~COMMONWEALTH OF VIRGINIA~~ STATE OF TENNESSEE

COUNTY OF WASHINGTON SULLIVAN

Personally appeared before me, a Notary Public in and for the State and County aforesaid, the within named bargainer, **BARBARA LEIGH JANE WELCH**, with whom I am personally acquainted, or whose identity has been sufficiently proven to me, and who acknowledged that he/she executed the within named document, consisting of **two (2)** typewritten pages, for the purposes therein contained.

Witness my hand at office this 6 day of SEPTEMBER, 20 19.


Notary Public

My commission expires: 7/24/23



My Commission Expires July 17, 2021

AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, EMPLOYMENT and EDUCATION RECORDS
INFORMATION

TO: BALLAD HEALTH
ATTENTION: Medical Records
400 North State of Franklin Rd.
Johnson City, TN 37604

RE: Barbara Welch

SS#: 228-60-0602

DOB: February 20, 1945

a. Release of Individually-identifiable health information, pursuant to HIPAA and other applicable Federal and state laws, regulations and case/administrative decisions:

I, Barbara Welch, hereby authorize the disclosure of individually identifiable health information as described below:

All information and records concerning my Protected Health Information, as defined by the HIPAA regulations, including, but not limited to, all medical records, physician's records, surgeon's records, information and records concerning my physical condition and treatment, information and records concerning my mental condition and treatment, records of all diagnostic tests, including, but not limited to, x-rays, CT scans, MRI films, photographs, and any other radiologic, nuclear medical or radiation materials, all pathology materials, including slides, tissues, and laboratory reports of whatever nature, discharge summaries, progress notes, records of consultations, records of prescriptions, medical history and physicals, all nurse's notes and records, patient intake forms, all correspondence contained in any file you are keeping on me, all psychiatric and psychological records, including any such records relative to psychiatric or psychological treatment described above, all records from any social worker, all records in your file relevant to any insurance claims, all consents for treatment or examination of whatever kind, all records relative to any periods or stays of hospitalization in any type of facility for any length, including voluntary or involuntary confinement, any information related to sexually transmitted disease, including, but not limited to, HIV and AIDS-related illnesses, any record of any type of substance abuse or treatment, and, generally, any and everything related to the above not specifically set forth above.

In connection therewith, I hereby authorize any doctors, nurses, x-ray technicians, chiropractors, osteopathic physicians, psychiatrists, psychologists, therapists, specialists, any and all other medical personnel and healthcare facilities or providers of any kind and nature to disclose to and provide copies of the above information to the following: BALLAD HEALTH, ATTN: Mr. Alan Levine and/or Mr. Timothy Belisle, 400 North State of Franklin Rd. (and/or 303 Med Tech Parkway) Johnson City, TN 37604

b. General Provisions

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By my signature below, I understand and agree (a) that once the above information is disclosed, there is potential for the designated recipient, unless prohibited by Federal or State statute or court/administrative order, to redisclose the information requested, and that the information may no longer be protected by Federal or State privacy laws and/or regulations; (b) that the provider furnishing the copies may receive compensation for doing so; (c) that I may refuse to give consent to access to and release of this information, but that the information may still be obtained pursuant to judicially-mandated discovery; (d) that I may revoke this authorization at any time by giving written notice to the persons or entities authorized to receive this information as designated above, except that a

revocation of this Authorization will not apply to records already received before its revocation; (e) that (1) I am at least eighteen (18) years of age, and of sound mind as of the date of my execution of this Authorization, and that no force, threats, coercion or other intimidation has been utilized to procure my signature below, OR (2) that, if I am the parent, conservator, legal guardian, and/or custodian of a person either not of legal age, or adjudged legally incompetent, if of legal age, I am legally authorized to execute this Authorization on this person's behalf, and I do so without the application of force, threats, coercion or other intimidation.

Date

Barbara Welch
Signature of Patient (Person Authorizing Release), or
Legal Representative

(If the signatory is a Legal Representative: The authority I have to act for such person is as follows: N/A)

~~COMMONWEALTH OF VIRGINIA~~ State of Tennessee
Sullivan
~~COUNTY OF WASHINGTON~~

Personally appeared before me, a Notary Public in and for the State and County aforesaid, the within named bargainor, **BARBARA WELCH**, with whom I am personally acquainted, or whose identity has been sufficiently proven to me, and who acknowledged that he/she executed the within named document, consisting of **two (2)** typewritten pages, for the purposes therein contained.

Witness my hand at office this 18th day of February, 2020.

Holly L. Hawkins
Notary Public

MY COMMISSION EXPIRES SEPTEMBER 29, 2021

My commission expires: _____



PLAINTIFF'S EXHIBIT B:
CERTIFICATE OF GOOD FAITH

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN

DISTRICT OF TENNESSEE, AT GREENEVILLE:

BARBARA WELCH

Plaintiff

VERSUS

BALLAD HEALTH

Defendant

CASE NO.:

JURY DEMANDED

CERTIFICATE OF GOOD FAITH

Medical Malpractice Case

PLAINTIFF'S FORM

A. In accordance with T.C.A. § 29-26-122, I hereby state the following: (Check item 1 or 2 below and sign your name beneath the item you have checked, verifying the information you have checked. Failure to check item 1 or 2 and/or not signing item 1 or 2 will make this case subject to dismissal with prejudice.)

XX 1. Plaintiff's counsel has consulted with one (1) or more experts who have provided a signed written statement confirming that upon information and belief they:

(A) Are competent under TCA § 29-26-115 to express opinion(s) in the case; and

(B) Believe, based on the information available from the medical records concerning the care and treatment of the Plaintiff for the incident(s) at issue, that there is a good faith basis to maintain the

action consistent with the requirements of TCA § 29-26-115.



Signature of Plaintiff's Counsel

B. You MUST complete the information below and sign:

I have been found in violation of T.C.A. § 29-26-122 ZERO (0) prior times. (Insert number of prior violations by you.)



Signature of Person Executing This Document



Date

PLAINTIFF'S EXHIBIT C:
**AFFIDAVIT OF COMPLIANCE WITH
PROVISIONS OF TENNESSEE HEALTHCARE
LIABILITY ACT, EXECUTED BY PLAINTIFF'S
ATTORNEY AND HIS SECRETARY**

AFFIDAVIT PURSUANT TO TCA § 29-26-121 (a) (4)

STATE OF TENNESSEE

COUNTY OF GREENE

FRANCIS X. SANTORE, JR., and ROSALIE E. BROOKS, after having been duly sworn, depose and say as follows:

1. We are the attorney for, and the secretary for the attorney for, respectively, the plaintiff in the instant health care liability action:

2. On **February 19, 2020** we prepared the required pre-suit notice letters, with all the required information thereon and many **HIPAA**-compliant medical authorizations contained therein, as required by the Tennessee Healthcare Liability Act.

3. All such pre-suit notice letters and required enclosures were received by the recipients on the dates shown on the return receipts for the certified mailings (i.e. the "green cards") for each. And, the date of mailing of each notice is shown by the receipt for postage. The certified mail number on the receipt for postage matches up with the green card on each of the mailings, showing proof of receipt of notice. (See **Exhibit A** to this Complaint).

4. We, thus, aver that we have complied with the mandates of **TCA § 29-26-121**, as we sent (a) the required pre-suit notice containing all the requisites therein to each defendant and (b) a series of **HIPAA**-compliant medical authorizations to each defendant, as shown by other exhibits attached to this Complaint. Further, deponents saith not.


Francis X. Santore, Jr.


Rosalie E. Brooks

Sworn and subscribed before me this 11 day of JUNE, 2020.


Notary Public

My commission expires: 2-28-23.

